



Department of Workforce Services
Employment Termination

ATTENTION EMPLOYMENT COUNSELOR: Complete this section and the last section before giving the form to the customer.

Customer Name _____ Case Number _____
Social Security Number _____ Date _____
Employment Counselor _____ **Phone** _____ **Fax** _____

ATTENTION CUSTOMER: (Please read and sign)

I authorize any person or institution to release information to the Department of Workforce Services. I understand that this information is **confidential** and will be used only to prove my eligibility for benefits or to determine an appropriate level of participation in employment activities. Any person or institution that gives this information is released from any liability.

Customer Signature

Date

Have you filed for Unemployment Insurance? " Yes " No

Unemployment Claims number: (801) 526-4400 or toll free 1-888-848-0688

Remember changes of employment need to be reported within 10 days of the change.

ATTENTION EMPLOYER: Complete this section and return to DWS Employment Counselor.

The above named customer reports she/he no longer works for you. Please provide the following information within 10 days to the Employment Counselor listed above. Do NOT send this form to the Unemployment office.

Was this employee working more than 30 hours per week earning minimum wage or more? ___ Yes ___ No

Date of hire: _____ Last day worked: _____

Date final check available to the employee: _____

Gross amount of last paycheck: \$ _____

Total **gross pay** employee received in the final month: \$ _____

Reason for leaving: " Quit (list reason) _____ " Laid off (date) _____

" Fired (list reason) _____ " Leave of absence (length) _____

" Other (reason) _____

Is there an option for continued medical insurance? " Yes " No If yes, at what cost? _____

Does the employee have any retirement and/or 401K benefits? ☐ Yes ☐ No If yes, how much? _____

Any additional comments: _____

Name of Company

Phone Number

Position/title

Printed Name

Signature

Date